IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 696

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of Shyra Lee Bloomfield

Delivered On:	18 July 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria 3000
Hearing Dates:	8 – 10 November 2010
Findings of:	CORONER JACQUI HAWKINS
Representation:	Mr D Gibson appeared on behalf of relatives of the deceased Mr D Masel SC appeared on behalf of the Department of Education and Early Childhood Development Ms E Gardiner appeared on behalf of the Department of Human Services
Police Coronial Support Unit	Leading Senior Constable G McFarlane appeared to assist the Coroner.

I, JACQUI HAWKINS, Coroner, having reviewed the investigation into the death of SHYRA LEE BLOOMFIELD

AND the inquest[1] held by Coroner Hendtlass on 8-10 November 2010

at Coroners Court of Victoria, Level 11, 222 Exhibition Street, Melbourne,

find that the identity of the deceased was SHYRA LEE BLOOMFIELD

born on 22 November 1991

and the death occurred on 16 February 2008

at 10 Tanilba Street, Werribee

from:

1 (a) HANGING

in the following circumstances:

1. Ms Shyra Lee Bloomfield[2] was a 16 year old young person of Aboriginal descent. She had three siblings and lived predominantly with her mother Tania McPhelim and step-father John McPhelim at 10 Tanilba Street, Werribee. For a few months prior to her death Shyra had experienced accommodation instability and had spent some time living out of home with her boyfriend, Michael Daniels.
2. In her short life, Shyra was exposed to a number of confronting and distressing experiences including family violence, drug and alcohol abuse, and self-harm by her parents. Shyra also faced a number of obstacles with learning from an early age. As a teenager, Shyra had ongoing difficulties with reading and writing. Since 2000, the Department of Human Services (DHS), including Child Protection was intermittently involved in her welfare and development.
3. Shyra started chroming[3] at age 11 and this behaviour increased over time until it became an addiction. The chroming would occur in abandoned houses, under bridges and along the Werribee River.
4. At 13 years old, Shyra developed a relationship with Mr Daniels who was then 18 years old. This relationship is reported to have become sexual in nature around the time Shyra turned 14.

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1 This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

2 For the purpose of this finding I will refer to Shyra Lee Bloomfield as "Shyra".

3 Chroming consists of spraying paint (chrome) from an aerosol can into a plastic bag and then breathing in the vapours from the bag. Drugs and Crime Prevention Committee; *Inquiry into the Inhalation of Volatile Substances: A Discussion Paper*, Parliament of Victoria, January 2002, p9

5. The period of Child Protection involvement most proximate to Shyra's death commenced with a report made on 9 July 2006. Following this report, an Interim Child Protection Order was issued on 19 October 2006. On 7 February 2007, Shyra was made the subject of a permanent Child Protection Supervision Order which was the subject of an application for extension to be heard on Monday 18 February 2008.

6. There was evidence that in the time leading up to her death, Shyra showed signs of improvement and was beginning to develop an interest in her heritage and cultural identity.

7. On 15 February 2008 Shyra met up with two friends at a vacant house in Werribee and chromed. Shyra had recently broken up with Mr Daniels and was upset about the end of this relationship. Her friends noted that once the chroming had taken affect Shyra appeared happy.

8. At about 12.30am on Saturday 16 February 2008, Shyra left the vacant house and walked home. Ms Fulton thought it was strange that she was going home and noted that although Shyra was not crying she did appear upset.

9. At approximately 1.30am, Shyra telephoned Mr Daniels and they had an argument. Mr Daniels indicated that she was drug effected and angry with him. He told her to call him back when she was not angry. Shyra attempted to call him back two more times however he did not take the calls.

10. At approximately 6.30am, Mr McPhelim found Shyra in the garage hanging with an electrical cord and sought assistance from a neighbour to cut her down. Police and ambulance attended and on arrival determined that Shyra was deceased.

JURISDICTION

11. At the time of Shyra's death the Coroners Act 1985 (Vic) applied. From 1 November 2009, the Coroners Act 2008 (Coroners Act) has applied to the finalisation of investigations into deaths that occurred prior to its introduction.

12. The Coroners Court of Victoria is an inquisitorial jurisdiction.[4] Section 67 of the Coroners Act provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

13. The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

14. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority

4 Section 89(4) of the Coroners Act.

or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[5]

ASSIGNMENT OF INQUEST FINDINGS

15. Coroner Hendtlass retired on 31 December 2013 without completing the inquest findings in this investigation. The State Coroner of Victoria, His Honour Judge Gray, assigned the completion of this Finding into Death with Inquest (Finding) to me pursuant to section 96 of the Coroners Act.

16. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all the witness statements contained within the inquest brief, supplementary statements, exhibits and transcripts of both directions hearings and the Inquest.

CORONIAL INVESTIGATION AND INQUEST

17. Coroner Hendtlass conducted an investigation and held an inquest into Shyra's death on 8, 9 and 10 November 2010.

18. At the conclusion of the Inquest interested parties provided written submissions which I have considered for the purpose of this finding.

Viva Voce evidence at the Inquest

19. The following witnesses gave viva voce evidence at the Inquest:

- Ms Tania McPhelim, Shyra's mother;
- Mr Michael Daniels, Shyra's ex-boyfriend;6
- Ms Lisa Calder (nee Cuckow), Team Leader, Child Protection, DHS;
- Ms Alida Verschuur, Coordinator of Detox Unit, Salvation Army;
- Ms Janet Ray, Education Support Worker, Western Education Services;
- Ms Maria Martin, Assistant Child Protection Manager, DHS; and
- Mr Ian Claridge, General Manager, Student Wellbeing, Department of Education and Early Childhood Development

Issues investigated

20. Section 67 of the Coroners Act requires me to find:

  a) the identity of the deceased

  b) the cause of death, and

  c) the circumstances in which the death occurred.

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5 Sections 72(1) and (2) of the Coroners Act.

6 A successful application was made pursuant to section 57 of the Coroners Act for Michael Daniels to be granted a certificate pursuant to section 57(1)(b) of the Coroners Act, which enables the witness to give evidence without that evidence being used in any proceeding against him.

IDENTITY OF THE DECEASED

21. I find that the identity of Shyra Lee Bloomfield was without dispute and required no additional investigation.

CAUSE OF DEATH

22. Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted a post mortem examination on 18 February 2008. Dr Burke attributed Shyra's death to 1a) HANGING.[7]

23. Toxicological analysis showed no evidence of alcohol or common drugs or poisons.[8]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

24. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

Issues investigated as part of the Inquest

25. For the purpose of this Finding I have considered the following issues:

- Shyra's Cultural Identity;
- Contact with the Department of Human Services, Child Protection;
- Shyra's engagement with education;
- Shyra's dependency on chroming;
- Assessment of Suicide Risk; and
- Recommendations made by the Child Services Commissioner.

Shyra's Cultural Identity

26. Central to the identity of a young Aboriginal person are cultural awareness and an understanding of their heritage. In this sense, any consideration of the circumstances of Shyra's death must necessarily encompass an appreciation of her lived cultural experiences.

27. Aboriginal teenagers straddle the divide between two cultures which creates an additional layer of complexity in navigating this period of life.[9] The evidence suggests that in the months preceding her death, Shyra was becoming increasingly interested in understanding her Aboriginal heritage.

28. Ms Ray said that she had a few conversations with Shyra about her identity and noted "this seemed to be an awakening issue for her where she was searching for some connection. Her

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7 Autopsy Report, Inquest brief, p47L

8 Toxicology Report, Inquest Brief, p47O

9 As part of the coronial investigation the court received a copy of the Victorian Aboriginal Child Care Agency (VACCA) *Aboriginal Youth Well Being Project Report*, December 2008. This project and subsequent report provided me with excellent insight and context into the dual world that Shyra cohabited.

knowledge of her Aboriginal heritage seemed limited".[10] Further "she was keen to do research of her background and this was built into tutoring sessions".[11]

29. According to Robert Ross, the Assistant Child Protection Manager, Aboriginal children and young people of all ages are significantly over-represented in all phases of child protection intervention across the state of Victoria.[12] Similarly, the *Dardee Boorai: Victorian Charter of Safety and Wellbeing for Aboriginal Children and Young People*[13] (the Charter) developed by the Victorian Government and Aboriginal communities recognises that, despite the strength of Aboriginal families and culture, many Aboriginal children and young people continue to experience significantly worse outcomes than non-Aboriginal children. The Charter acknowledges:

- Culture as central to building resilience and improving outcomes for Aboriginal children and young people;
- Collective responsibility for children;
- Opportunity to reach potential;
- Outcome focus; and
- The central importance of parents, family and community.[14]

30. Improving outcomes for Aboriginal young people is dependent on strong support and an appreciation of how formative cultural heritage can be in terms of identity. The Australian Human Rights Commission noted that "best practice responses require holistic culturally attuned, rights based and strengths based service delivery which is flexible and community controlled".[15]

31. In reviewing the service sector's engagement with Shyra, I have been mindful of how these overarching principles of cultural understanding and acknowledgement apply to her circumstances.

Contact with Department of Human Services, Child Protection

Background

32. Shyra first came to the attention of DHS on 17 October 2000. In total, Shyra was the subject of five reports to Child Protection, which included concerns relating to: family violence; alcohol abuse by Shyra's mother Ms McPhelim; drug use by Shyra's step-father; truancy from

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10 Exhibit 6– Statement of Ms Janet Ray dated 9 September 2008, p5

11 Exhibit 6– Statement of Ms Janet Ray 9 September 2008, p5

12 Statement of Mr Robert Ross, p7

13 *Dardee Boorai: Victorian Charter of Safety and Wellbeing for Aboriginal Children and Young People* 2008. from https://www.eduweb.vic.gov.au/edulibrary/public/govrel/Policy/thecharter/DardeeBooraicharter.pdf

14 *Dardee Boorai: Victorian Charter of Safety and Wellbeing for Aboriginal Children and Young People* 2008. from https://www.eduweb.vic.gov.au/edulibrary/public/govrel/Policy/thecharter/DardeeBooraicharter.pdf, p2

15 The Australian Human Rights Commission, *Preventing Crime and Promoting Rights for Indigenous Young People and Cognitive Disabilities and Mental Health Issues*, Sydney, HREOC, 2008 p65f.

school, learning difficulties and behavioural problems; absconding from home; and chroming.[16]

Concerns for Shyra's safety

33. The report initiating contact with Child Protection on 9 July 2006 centred on the exposure of Shyra to trauma associated with Ms McPhelim's poor mental health and self-harm. Ms McPhelim had experienced a decline in mental health which culminated in Shyra witnessing her mother attempt suicide by cutting her wrists. Ms McPhelim was assessed by a Crisis Assessment and Treatment Team as not suicidal but having a borderline personality disorder with poor social skills and poor impulse control.[17]

34. Shyra's contemporaneous personal difficulties related to her home life, education, chroming and her relationship with her boyfriend. This led Child Protection to issue a Protection Application on 28 August 2006, which indicated ongoing involvement and intervention with the family and that there were significant concerns.

Child Protection Engagement with Shyra

35. Ms Calder was allocated as the Child Protection practitioner for Shyra and her family in September 2006. On 19 October 2006, a three month Interim Protection Order was made and on 9 February 2007, Shyra was placed on a 12 month Supervision Order. The Supervision Order had special conditions including treatment for her substance abuse and the provision of support and that she reside at home and attend school.[18] The supervision order was in place at the time of her death and was the subject of an extension application which was due to be heard the following week.[19]

36. Shyra remained in the primary care of Ms McPhelim except when she was placed in a residential care facility between 9 and 11 January 2007 and Secure Welfare Service between 9 and 21 March 2007. During her admission to Secure Welfare she was assessed by a Take Two clinician as not requiring further mental health assessment or treatment.[20]

37. Ms McPhelim believed that the Child Protection workers could be a bit clinical and would enter the house with their pens and pads and appeared not to show much care towards Shyra. She suggested that DHS workers needed to show more feeling towards the children they work with. She further believed they needed to work not just with the child but with the family as a whole.[21]

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16 Exhibit 3 –Statement of Ms Lisa Calder (nee Cuckow) Inquest brief, p32

17 Exhibit 3 –Statement of Ms Lisa Calder (nee Cuckow) Inquest brief, p32

18 Exhibit 3 –Statement of Ms Lisa Calder (nee Cuckow) Inquest brief, p33, Transcript of evidence, p121 & p124

19 The Supervision Order was due to expire and on 4 February 2008. DHS made an application to the Childrens' Court to extend the order which was adjourned to 18 February 2008.

20 Exhibit 3 –Statement of Ms Lisa Calder (nee Cuckow) Inquest brief, p33

21 Transcript of evidence, p87

38. Ms Calder reflected that more attempts to have one on one time would have assisted Shyra to engage with some of the DHS programs and resources.[22] This would ideally have occurred fortnightly however it was made impossible by resource issues.[23] Further she stated that Shyra needed more intensive case management, consistency and stability and agreed with Ms McPhelim that Shyra needed someone she could trust.[24]

39. Ms Calder commented that she was concerned about Shyra's relationship with Mr Daniels due to his age and consulted with the Sexual Offences and Child Abuse Unit (SOCAU) of Victoria Police however was advised that without a statement of complaint no action could be taken.[25] Ms Calder testified that whilst she did not condone the relationship, she adopted a harm minimisation approach.[26]

40. Ms Calder said that Shyra had been exposed to a number of traumas in her life and had self esteem issues which led to a cyclical pattern of risk taking behaviours. Ms Calder had a significant amount of telephone and face to face contact with Ms McPhelim.[27] Counsel for Ms McPhelim conceded that Shyra's Child Protection practitioner made "significant and conscientious attempts to address Shyra's needs when she began working with her".[28]

Referrals by DHS to other support services

41. Shyra's situation was complex and challenging due to her chaotic life experiences. She was problematic to engage and would regularly cancel or avoid visits with Child Protection. Initially, Ms Calder made concerted efforts to build a relationship and make appropriate referrals to other support services like Youth Outreach Team (YOT) (Drug and Alcohol Service), TOTEM, WEST and CREATE to support Shyra.

42. Accordingly, Shyra had a plenitude of workers involved in various aspects of her life. Ms McPhelim commented that Shyra "had so many different people coming and going it just confused her and she just didn't like seeing so many different people and different workers all the time."[29] Further she added "I think she needed at least one person that she could trust with the majority of things that were going on in her life, besides having her mother she needed someone else that wasn't family".[30]

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22 Transcript of evidence, p128
23 Transcript of evidence, p171
24 Transcript of evidence, p177
25 Exhibit 3 –Statement of Ms Lisa Calder (nee Cuckow) Inquest brief, p33
26 Exhibit 3 –Statement of Ms Lisa Calder (nee Cuckow) Inquest brief, p34
27 Client Relationship Information System (CRIS) file
28 Submissions on behalf of Tania McPhelim dated 4 May 2011, p2
29 Transcript of evidence, p86
30 Transcript of evidence, p86

43. Ms Calder agreed and indicated that she was "very mindful not to continue to refer to multiple [services], because you don't want to overwhelm young people, or families with multiple [people] coming into their lives."[31]

Conclusions about contact with DHS

44. Shyra, like many of the children who come into contact with DHS, experienced a complex matrix of social and public health problems. This multifaceted front of obstacles presented significant difficulties for Child Protection workers. In particular, I acknowledge the difficult position of practitioners who operate under the constraints of limited resources which must be divided between many clients like Shyra who all need intensive support.

45. The evidence, when viewed as a whole, demonstrates the attempts made by Child Protection to assist Shyra were extensive and genuinely supported the aim of protecting her best interests. Individual practitioners, in particular Ms Calder, exhibited a dedication to Shyra that is commendable.

46. Shyra's multiple issues prompted Ms Calder to refer her to the High Risk Youth manager, however Shyra was not deemed high risk enough to be accepted. Alternatively, when Ms Calder explored a referral to the Adolescent Specialist Support Service, Shyra was deemed too high risk.[32] Unfortunately, Shyra balanced on the cusp of the inclusion criteria for both programs. This provides a stark example of the difficulties associated with supporting someone like Shyra in the Child Protection system, which I consider regrettable.

47. Ultimately it was conceded by Ms Calder that Shyra required more one on one support and guidance than was able to be provided given resourcing issues and Shyra's difficulty in engaging with the multiple services. I note that through the efforts of her engagement with Ms Calder Shyra was able to establish a meaningful relationship with Ms Calder.

48. In response to this issue and as a result of recommendations made by the Victorian Child Death Review Committee DHS advised that they were reviewing policies and guidelines relating to high risk adolescents, including the High Risk Adolescent Register to develop a consistent approach for these young people.[33]

Shyra's engagement with Education

Background

49. Shyra's education was of significant import for her family, her schools, Child Protection and subsequent referral agencies. Shyra attended Imaroo Primary School[34] from Grade Prep to Grade 6. In Grade Prep, she was diagnosed with a severe language disorder which inhibited her education and she was allocated an integration aid. Towards the latter part of her primary

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31 Transcript of evidence, p173

32 Transcript of evidence, p129

33 Submissions in Reply on Behalf of The Department of Human Services dated 27 June 2011 para 33

34 Imaroo was a State Government - Department of Education and Early Childhood Development school.

education, Shyra's attendance at school became problematic, due in part to her learning difficulties which are exacerbated by welfare concerns.

50. In 2003, Imaroo Primary School contacted Ms Nellie Flag who is a highly regarded Koori community elder and support person. Ms Flag investigated the potential for home tutoring and further assisted Shyra to enrol at Worowa Aboriginal College (Worowa) which is an independent Koori boarding school in Healesville.[35]

51. Shyra commenced Year 7 at Worowa in 2004. Her attendance there was chequered; she attended sporadically during 2004 and not at all during 2005. She returned at the beginning of the 2006 school year[36] however was shortly after expelled because of chroming, self harming and sexual promiscuity[37]. She was 14 years old.

52. It appears from the records of DEECD and Child Protection that, although she had not attained the minimum school leaving age of 15 years,[38] she did not enrol in any other secondary school. There is no evidence that Worowa implemented a plan for Shyra's enrolment elsewhere.

53. Mr Ian Claridge from DEECD believed that "Worowa would have a fundamental obligation as an educational institution to ensure that appropriate transition arrangements were in place for Shyra particularly given her long and complex history".[39] He considered that communication with the previous school would have been fundamental.[40] However, I note that Worowa were not called to give evidence or provide a statement and I am therefore unable to properly assess the veracity of this evidence and the appropriateness of their actions.

54. There was some discussion about Shyra attending Gilmore Girls School in Footscray however Ms McPhelim said they turned her down because she was not up to the level.[41]

55. Ms Ray felt that leaving Worowa Shyra "[...] fell through the cracks, she sort of disappeared from sight in terms of the educational system".[42] However, after Child Protection became involved with Shyra in July 2006, they referred her to MacKillop Family Services (MacKillop) and other agencies in an attempt to re-connect her with the education system.

56. A neuropsychology assessment was conducted by 'Take Two' during her attendance at Secure Welfare in March 2007. The assessment report noted that in relation to aspects of her

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35 Statement of Nella Cascone, Inquest brief

36 Submissions of the Department of Education and Early Childhood Development (DEECD), p2

37 Exhibit 3 –Statement of Ms Lisa Calder (nee Cuckow) Inquest brief, p33

38 The minimum school age has recently been amended a number of times, Submissions for DEECD note that the minimum compulsory school age was at 1 July 2007 – 15, from 1 July 2007 to 1 January 2010 – 16 years, and from 1 January 2010, 17 years subject to certain exemptions, see pp9-10

39 Transcript of evidence, p338

40 Transcript of evidence, p338

41 Transcript of evidence, p65

42 Transcript of evidence, p301

cognitive function, Shyra had a "wide variation of scores from borderline to high average."[43] Further the overall results indicated that Shyra should not be overloaded with information and may benefit from support in completing tasks with increased cognitive demand.[44]

57. The report made a number of recommendations including that Shyra would benefit from a carefully planned reintegration into education and may be eligible for a referral to an Aboriginal youth education worker.[45]

Engagement with MacKillop Family Services

58. On 24 January 2007, Shyra was referred by DHS to MacKillop who work exclusively with children subject to DHS orders.[46] Their primary role is to assist young people who have difficulty in mainstream schooling reintegrate into the education system.[47] It was commonly agreed between the DEECD witnesses and those from DHS that it would have been very difficult for Shyra to re-enter mainstream school due to the amount of time she had been out of it.

59. Enquiries were made about the possibility of Shyra being allocated an education support worker through Western Education Support Team (WEST).[48] However, Shyra was only on an Interim Accommodation Order and therefore not eligible for the service at that time. However, she was placed on a waiting list pending the making of a statutory order.[49] On 17 August 2007, after the Supervision Order was made and a vacancy was available, WEST opened a file for Shyra.

60. In the first instance, Sally Tyrell was the support person allocated and from October 2007, Shyra was allocated the support of Ms Ray. Ms Tyrell and Ms Ray facilitated assistance with her numeracy and literacy and focussed on returning her to education in some form.[50]

61. I note Ms Ray's considerable expertise and experience in this area; she is a qualified teacher, holds a post graduate certificate in adolescent health and welfare, worked in a crisis youth refuge for 10 years and was a mental health worker for 10 years.[51]

62. Ms Ray saw Shyra regularly and it is evident that she had formed a good working relationship with her. Ms Ray commented that she believes young people need goals to work towards so that they have something else to do with their time.[52] To this end, she developed an Individual

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[43] Exhibit 8 – MacKillop Family Services file, Neuropsychology Report dated 20 March 2007, p3
[44] Exhibit 8 – MacKillop Family Services file, Neuropsychology Report dated 20 March 2007, p3
[45] Exhibit 8 – MacKillop Family Services file, Neuropsychology Report dated 20 March 2007. p3
[46] Transcript of evidence, p265
[47] Transcript of evidence, p133
[48] Exhibit 6 – Statement of Ms Ray dated 9 September 2008, p1, WEST is a joint venture between MacKillop and the Salvation Army Westcare, funded by State and Federal departments
[49] Exhibit 6 – Statement of Ms Janet Ray dated 9 September 2008, p
[50] Exhibit 6 – Statement of Ms Janet Ray, Inquest brief, p47D and Transcript of evidence p 272
[51] Transcript of evidence, p296-297
[52] Transcript of evidence, p251

Education Plan for Shyra, which provided goals to find part time work, commence tutoring in preparation for returning to school, attend school from the start of February 2008 and highlighted her interest in taking some art classes.[53] Ms Ray reported a number of intervention actions she had taken and positive outcomes achieved.

63. Ms Ray found that Shyra "was really engaged, friendly, very, very… nervous about re-entering the education system or taking on school again, but she was really brave and wanted to make a go of it".[54] Ms Ray further indicated that Shyra was quite engaged in this process.

Cancellation of the WCIG Course

64. Shyra was also referred to the Westgate Community Initiative Group (WCIG) in Werribee by MacKillop.[55] WCIG provided an alternative option to mainstream schooling and could be accessed by young people who had disengaged from education.[56] Shyra had been accepted into the Victorian Certificate of Applied Learning course at WCIG which was due to commence in February 2008.

65. This course was a promising prospect for Shyra because it met the dual requirements of her interest and was well suited to her learning needs. Ms Ray had assisted Shyra with this enrolment and through concerted efforts had reached a point where Shyra was prepared to attend and was excited about this occurring. MacKillop had purchased a computer, printer and desk, which was given to Shyra in November 2007[57] and some new clothes in anticipation of the course commencing.

66. However, a late cancellation of the course in 2007 meant that Shyra did not ultimately benefit from Ms Ray's preparatory work or the course itself. This was particularly problematic because Ms Ray was then in the difficult position of needing to get Shyra engaged and mentally ready to undertake something new at short notice. According to Ms Ray, Shyra was quite distraught when the program did not go ahead and it appears Shyra's chroming increased when she missed out on this opportunity.[58]

Multi-Service Intervention Response Team (MIRT)

67. Mr Ian Claridge discussed a project called the Multi-Service Intervention Response Team (MIRT). MIRT was a multidisciplinary panel which brought together key stakeholders and met monthly to facilitate educational planning and problem solving for children and young people at risk of exclusion from mainstream schooling.[59]

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53 Transcript of evidence, p251
54 Transcript of evidence, p244
55 Inquest brief, p47D
56 Inquest brief, p47D
57 Exhibit 6 – Statement of Ms Janet Ray dated 9 September 2008, p3
58 Transcript of evidence, pp253 and 258
59 Transcript of evidence, p278

68. It appears that Shyra's situation was never raised with MIRT. Ms Ray stated "I think that my co-ordinator, who sits on MIRT, would have been aware of what was happening at that time. So it may have been .... thought about and then not followed through for some other reason."[60] She noted in this context that she believed increased communication is always be a good thing.

69. Ms Calder testified that she was aware of a board that could be consulted about difficult clients not engaging in education, however it appears that she did not have any direct knowledge of MIRT. She lamented that if she had known of MIRT's existence, it would have been an avenue that she would have discussed pursuing with her manager.[61]

70. Had Shyra's case been brought to MIRT, her best interests would have been considered by a group of experienced personnel including child psychologists, protective workers and mental health specialists with expertise in the educational resources and programs available to Shyra. However, I am unable to determine whether a referral to MIRT would have resulted in an appropriate alternative to her educational needs.

Conclusions as to education

71. Shyra's evident disengagement with the education system was a cause for concern. Ms Ray commented that by the time of her death, Shyra had essentially left mainstream education.[62] This disengagement was in turn compounded by her difficulty with learning. Ms McPhelim commented that Shyra really wished that she was able to read, write and learn like other children which was a source of embarrassment for her.[63]

72. Efforts by DHS and MacKillop to assist Shyra with finding education suitable to her needs were concerted. Of particular note is the excellent working relationship established by Ms Ray in the months preceding Shyra's death. The effectiveness of this relationship was unfortunately impacted by the unforeseen cancellation of a course that Shyra had been prepared extensively to attend and about which she was excited. However, Ms Ray noted that:

> the majority of mainstream and alternative DEECD options are not suitable for young people who exhibit high risk behaviours. Programs are needed that are flexible and individually tailored to the needs of young people with complex needs.[64]

73. A suggestion was made at inquest that there was potentially a need for resources to be allocated to more flexible learning options.[65] While services have been established to assist children with their education and facilitate their ability to engage with the system, children do have self-determination and they must exhibit a concomitant willingness and preparedness to

60 Transcript of evidence, p286
61 Transcript of evidence, p194
62 Transcript of evidence, p254
63 Transcript of evidence, p62
64 Exhibit 6 – Statement of Ms Janet Ray dated 9 September 2008, p4
65 Transcript of evidence, p344

do so. To this end, I agree that it is important to have flexible learning options that cater for the needs and interests of individuals who have experienced ongoing problems with conventional forms of education.

74. It is unfortunate that following her expulsion from Worowa Shyra fell through the gaps in the education system. However, it is also worth noting the unlikelihood that this would occur again in the context of the current system. Specifically, the introduction in 2009 of the Unique Student Identifier (Victorian Student Number – VSN)[66] means that the education system would easily identify a student's non-enrolment.[67]

Shyra's dependency on chroming

Nature and frequency

75. The evidence suggests that Shyra had an addiction to chroming which involves spraying paint (chrome) from an aerosol can into a container or a plastic bag and then inhaling the vapours.[68] The inhalants produce chemical vapours that can induce a mind altering effect and intoxication.[69] Shyra commenced chroming when she was 11 years old. It is believed that at her peak Shyra was using 8 to 10 bags of chrome (or between one and two cans of spray paint per day).

76. Shyra advised DHS that she chromed due to boredom and because it gave her a buzz.[70] When Shyra was placed in Secure Welfare she was assessed by Ms Verschuur, a drug and alcohol consultant. Ms Verschuur believed Shyra's addiction was most likely to be psychological due to the length of time she had been using it.[71]

Physiological and psychological effect of chroming

77. Chroming has different physiological and psychological impacts on young people. The effects of inhalants can last from 5 to 45 minutes and can reduce inhibitions and cause feelings of wellbeing, hallucinations, drowsiness, vomiting, diarrhoea, nosebleeds, sores and flu-like symptoms. Large doses can cause disorientation, un-coordination and unconsciousness.[72]

78. One of the reasons Ms Verschuur gave for why young people chrome is that "it's a very short acting period of obliteration, that they're not feeling or sensing anything, so - yes, it's a cheap introversion of disconnecting with what else is going, or not going on".[73]

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66 Exhibit 9 – Statement of Mr Ian Claridge, pp5-6, Transcript of evidence, p339

67 Transcript of evidence, p337

68 Drugs and Crime Prevention Committee; *Inquiry into the Inhalation of Volatile Substances: A Discussion Paper*, Parliament of Victoria, January 2002, p9 and Alcohol and other Drugs Council of Australia, *Inhalants*, Inquest brief, p73

69 Alcohol and other Drugs Council of Australia, *Inhalants*, Inquest brief, p72

70 Transcript of evidence, p200 and p135

71 Transcript of evidence, p211

72 Alcohol and other Drugs Council of Australia, *Inhalants*, Inquest brief, p73

73 Transcript of evidence, p216

79. Ms McPhelim had observed Shyra when she was effected and said that "sometimes she'd come in very, very, very white, pale, [with] different colour paint around her mouth...she'd get very hostile and ... aggressive".[74] Ms Calder reported that Ms McPhelim had previously advised her that Shyra became violent and aggressive when chroming.[75]

Treatment and rehabilitation

80. Treatment interventions for chroming include detoxification, individual counselling and group work.[76] There is evidence that Shyra went through fluctuating periods of increased chroming followed by attempts to decrease use. According to Mr Daniels they both wanted to stop but never really knew how.[77]

81. Referrals to drug and alcohol counselling are made available through DHS. Shyra was allocated a Youth Outreach Worker, Michael Anderson, to assist with her chroming and other substance abuse. However, Shyra told Ms Calder that she was uncomfortable with a male worker and consequently never really engaged in any drug and alcohol rehabilitation.[78]

82. Ms Verschuur noted that during her assessment, Shyra had told her she was frightened of treatment. Mr Ross believes that although you cannot force a young person to attend, they can be strongly encouraged to participate in assessment and treatment.[79] Ms Verschuur agreed that aggressive intervention with adolescents does not work. She indicated that she wanted to help Shyra understand the significance of chroming and to give her the impression that treatment was not a "huge thing" but was something that needed to happen.[80]

83. Ms Verschuur seemed to advocate for an approach that focussed on family as well as the individual. She said "success comes when you engage with the mother, and the source of where the attachment is, and if ..the mother's not happy with what's happening, then...the child won't engage."[81]

84. Ms Verschuur was also of the belief that DHS workers should have a basic understanding of drug and alcohol issues as well as mental health issues so that they can identify a client with these problems more easily and better assist them with any treatment. [82] Ms Calder supported this idea and said it would have been beneficial to have received training around chroming.[83]

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74 Transcript of evidence, p74
75 Exhibit 3 - Statement of Ms Lisa Calder (nee Cuckow), Inquest brief, p34
76 Statement of Mr Robert Ross, p3
77 Transcript of evidence, p98
78 Transcript of evidence, p150
79 Statement of Mr Robert Ross, p3
80 Transcript of evidence, p210
81 Transcript of evidence, p221
82 Transcript of evidence, p229
83 Transcript of evidence, p200

Restricting Access

85. It was suggested that young people chrome because the spray paint is easily accessible and cheap to purchase. Mr Daniel for example said "they're quite easily (sic) to get, we could steal them from $2 shops or they were only cheap to buy, $3.50, you'd get them from markets, they're nearly sold all over Melbourne".[84]

86. This is consistent with Ms McPhelim belief that Shyra and her friends would steal the cans if they did not have the money.[85] She further said that sometimes she would find the paint in Shyra's bags, stashed under her bed, outside in the backyard or out through her window.[86]

87. There is, and was at the time of Shyra's death, no legislative framework regulating the sale of volatile products used for chroming in Victoria. These products are exempt from scheduling as drugs or poisons and it is legal to purchase spray paint.[87] Although some states do restrict the sale of inhalant products including paint to people under 18, this is not the case in Victoria. However, there are some alternative measures which can be used to prevent chroming, including a power for Victoria Police to apprehend a person under 18 years who is reasonably suspected of abusing volatile substances.[88]

88. A Parliamentary report into Drugs and Crime Prevention made the following comment:

> There is no one solution to address volatile substance abuse. Supply side measures cannot be seen in isolation from education programmes. Demand reduction will not work without some consideration of the legislative frameworks needed to address the issue. Scientific modification of products will be useless without strategies that address the underlying factors that cause young people to use drugs, including volatile substances.[89]

89. Mr Tony Addley, Acting Director of Community Development for the Wyndham City Council believes that banning all solvents including aerosol cans is not a viable option because of their legitimate domestic and commercial applications. He said that given many substances are normal household products that are readily available from supermarkets, supply reduction strategies are also likely to impose barriers on people who legitimately wish to use the products for their intended purpose.[90]

90. Further research needs to be conducted around the effectiveness and appropriateness of restricting access to volatile substances such as chrome paint as a viable solution. Another alternative to consider is whether there should be more education and counselling about the

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84 Transcript of evidence, p98

85 Transcript of evidence, p74

86 Transcript of evidence, p74

87 Statement of Ms Anna Gifford, Resource Centre Manager, Australian Drug Foundation, Inquest brief, 47A

88 Statement of Ms Anna Gifford, Resource Centre Manager, Australian Drug Foundation, Inquest brief, 47A

89 Victorian Parliament, Drugs and Crime Prevention Committee, *Inquiry into the Inhalation of Volatile Substances: Final Report* (2002), Government Printer, http://www.parliament.vic.gov.au/images/stories/committees/dcpc/Volatile_substances/Volatile_Substances_discuss_paper1.pdf

90 Transcript of evidence, p37

risks and effects chroming. What is already clear however, is that there needs to be a comprehensive and whole of community response.

Summary in relation to chroming

91. The weight of the evidence indicates that Shyra was addicted to chroming and would have benefitted greatly from drug and alcohol counselling and assistance with withdrawal. I acknowledge that the issue of chroming is complex and particularly so in Shyra's case because of the confluence of other psycho-social difficulties she was facing at the time.

92. I recognise that when in Secure Welfare and her access to chroming was restricted, Shyra started to look healthier and gain weight. The benefits of this restriction from a rehabilitation perspective are clear and I therefore commend that it occurred. It is possible that a further period of such intensive rehabilitation would have been the only way to assist Shyra. However, without engagement in an educative program, Shyra would have been prone to re-connecting with her friends that were not at school and re-commence chroming.

Assessment of Suicide Risk

93. There is evidence that Shyra experienced a number of stressors over the course of her life. She had been exposed by her family to drug and alcohol abuse, family violence and problems associated with mental illness. In addition, she had been involved with child protection from a young age. There is also evidence that Shyra's chroming, difficulty with the education system and her relationship with Mr Daniels (which by some reports involved family violence) were all stressors proximate to her death. Moreover, the impended court date to renew the Supervision Order may also have been an operant stressor.

94. On 12 February 2008, Shyra stayed out overnight and in the morning of 13 February engaged in self harming behaviour by cutting her arm. According to Ms McPhelim, Shyra said she could not handle the pain anymore.[91] Despite this incident, Ms McPhelim did not consider that Shyra was suicidal, however she was very concerned that she may have an accident as a result of chroming.[92]

95. Ms Calder had contact with Shyra on and around the day she died and reported that she did not assess Shyra as suicidal or at risk of self harm. The evidence of Ms Calder was that there was "no indication that [Shyra] was suicidal, or that she would suicide or self harm".[93] She considered that Shyra was planning for the future as was evidenced by her proposal to move to her Aunt's home and her arrangements to meet Ms Calder and Ms Ray on 18 February 2008 to extend the Supervision Order.[94] Ms Calder specifically noted that she had not been

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91 Exhibit 1 – Statement of Tania McPhelim, p15; Exhibit 3, Statement of Ms Lisa Calder (nee Cuckow); Inquest brief, pp36-37; Transcript of evidence, p57-59

92 Transcript of evidence, p37

93 Transcript of evidence, p121

94 Exhibit 3, Statement of Ms Lisa Calder (nee Cuckow); Inquest brief, p37

made aware that Shyra had engaged in self harming behaviour on the morning of 13 February 2008.

96. Conversely, Ms Ray stated she was beginning to have concerns about Shyra on her last visit, however did not expect her to take her own life.[95] Ms Ray raised concerns with Ms Calder about Shyra's mental health because she thought Shyra was exhibiting paranoid behaviour.[96]

97. Importantly, a Client Relationship Information System (CRIS) file note made by Lesley Harding on 21 December 2007 indicated that Ms Calder had provided a briefing to her that expressed concern regarding Shyra's mental health and suicidal thoughts, however at Inquest Ms Calder had no recollections of these concerns.[97]

98. Ms McPhelim suggested there needed to be a greater understanding of suicide and self-harm as a phenomenon, particularly in relation to children. An awareness of how they are feeling and how they are thinking would be useful because it is such a critical age.[98]

Conclusion about assessment of suicide risk

99. There was no evidence Shyra was suffering from any specific mental ill health at the time of her death. Her friends did not consider her to be at risk when she left them that evening. It appears that Shyra may have been experiencing a situational crisis associated with the breakdown of her relationship with Mr Daniels which was exacerbated by her recent chroming. I consider it likely that she experienced difficulty rationalising her way out of these intense emotional feelings. However, I note these as contextual stressors only and accept that I am unable to find with any certainty the reason/s why Shyra decided to take her own life.

100. I accept the evidence of the people involved in Shyra's care and management that there was no specific evidence that Shyra was acutely suicidal or presented as being at risk of suicide or self harm.

Recommendations made by the Child Services Commissioner

101. The Victorian Child Services Commissioner made four recommendations that arose as a result of Shyra's death which were:

- Recommendation 20 - That the Department of Human Services ensures that practice standards support all young people known to Child Protection being engaged with educational services
- Recommendation 21- That the Department of Human Services ensures that hight risk adolescent processes identify all young people whose case management requires additional quality assurance monitoring and is not limited to cases receiving additional specialist resourcing.

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95 Exhibit 6– Statement of Ms Janet Ray, p5; Transcript of evidence, p312

96 Transcript of evidence, p297

97 Transcript of evidence, p196

98 Transcript of evidence, p86

- Recommendation 22 – That the Department of Human Services examines whether Aboriginal high risk adolescents receive sufficient access to Intensive Case Management Services (ICMS) and whether there is need for a specialist ICMS Aboriginal service response.
- Recommendation 23 – That the Department of Human Services undertakes a review of training materials used to promote an understanding of suicide risk in adolescents.[99]

102. Legal Submissions for DHS provided evidence that all four recommendations were accepted by DHS and at the time of the submissions remedial action was being taken.

FINDINGS

103. I find that Shyra Lee Bloomfield tragically died after she intentionally hanged herself from the garage with an electrical cord, understanding that it would end her life.

104. I further accept and adopt the medical cause of death provided by Dr Michael Burke and find that Shyra Lee Bloomfield died on 16 February 2008 from 1(a) HANGING.

105. I find that this occurred following an episode of chroming and shortly after a breakdown in her relationship with Mr Daniels. The decision to take her life therefore appears to have been made in the context of impaired decision making capacity as a result of illicit substance abuse and in response to a situational crisis with which Shyra was emotionally and psychologically ill-resourced to cope.

106. I acknowledge the impact Shyra's death has had on those who loved her. The tragic loss of a young adolescent life in these circumstances is heartbreaking and I express my sympathy to her family, friends and those who worked closely with her. In particular I would like to acknowledge that, within the limits of her capacity, Ms McPhelim demonstrated a resolve to assist Shyra with her problems and to fulfil her potential. I note that Ms McPhelim made numerous endeavours to seek and accept the support of services when she was unable to manage Shyra herself, although regrettably these efforts were ultimately to no avail.

107. In making my findings, I am conscious that, although short, Shyra led a troubled and chaotic life. Her learning difficulty and traumatic personal experiences made the normal vicissitudes of young adulthood even more difficult to manage. She was a vulnerable and complex young person and the importance of providing Shyra, and others like her, with stability and consistency cannot be underestimated.

108. Consideration must also be given to Shyra's identity as a young Aboriginal person, which was becoming an increasingly important factor in her life. Accordingly, I find that services should particularly be mindful of cultural identity when working with vulnerable children and young adolescents. A culturally aware approach to service provision is more likely to result in a

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99 Victorian Child Death Review Commissioner, *Annual Report of Inquiries into the deaths of children known to Child Protection,* 2010.

positive outcome; including more relevant and appropriate assistance and the potential to reduce the perception of isolation by harnessing the strength of community ties.

109. Despite the difficulties associated with Shyra's situation and circumstances, I find that Shyra did receive an appropriate level of support from Child Protection and I acknowledge that a number of different people were simultaneously seeking to assist her in the months prior to her death.

110. I find that the Child Protection workers, particularly Ms Calder were conscientious in their attempts to engage with Shyra and attempted to refer her to other support services. I acknowledge the intense work load and limited resources of Child Protection workers when it comes to providing support to multiple vulnerable young people particularly when they are resistant to engaging.

111. I acknowledge and accept that DHS have responded appropriately to recommendations of the Victorian Child Death Review Committee and implemented a number of changes to policies and procedures. For this reason I do not propose to make any recommendations. I encourage DHS, to use the opportunity this Finding presents to facilitate continuous improvements.

112. I find that at the time of Shyra's death she had been absent from mainstream education for an extended period of time. I find that other than a brief eight day attendance at Baltara School, (whilst in secure welfare), Shyra did not attend a government school after December 2003.

113. I find that Shyra was enrolled and expelled from Worowa at the beginning of 2006 having not reached the minimum school leaving age. After her expulsion it appears Shyra did not enrol in any other secondary school; in short she disappeared from the education system.

114. I find that Shyra's referral to MacKillop by DHS was a positive initiative and in particular I find that Ms Ray's immense efforts to assist and support Shyra with re-entering the education system was commendable. Our community benefits from workers such as Ms Ray who are committed to achieving better outcomes for our children and young people.

115. I find that that the cancellation of the Victorian Certificate of Applied Learning was a huge setback to Shyra's potential for future learning. Shyra appeared to be mentally prepared to make the transition back into an educational environment and was excited about the opportunity to continue learning. I acknowledge the enormous disappointment that Shyra would have experienced as a result of the cancellation of the course and the uncertainty she faced with this new situation.

116. Shyra's situation was complex because neither conventional forms of education nor alternative options were suitable to her requirements. I find Shyra required more flexible options that were tailored to meet her educational requirements.

117. I find the fact that Shyra's circumstances were not raised with collaborative organisations such as MIRT was potentially a missed opportunity. However I am unable to determine what impact this would ultimately have had.

118. Education is a fundamental human right of every child and young person and it is devastating that Shyra simply fell through the cracks.

119. I find based on all the available evidence that Shyra was addicted to chroming and would have benefitted greatly from rehabilitation including drug and alcohol counselling and assistance with withdrawal. However I appreciate the difficulties faced with obtaining her engagement in treatment.

120. I acknowledge the frustration of Ms McPhelim and Shyra's support workers felt in relation to her chroming. There is no easy solution to this inherently problematic, socially and developmentally detrimental practice. Nevertheless, given the dangers associated with it, as evidenced by the circumstances surrounding Shyra's death, the requirement for an effective solution is palpable and should be further investigated.

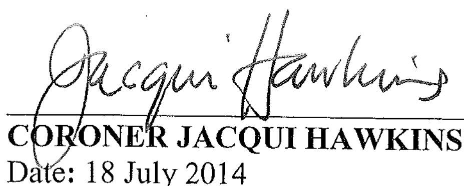
121. Although there was some suggestion that education should not have been the focus of intervention in Shyra's case because of the nature and extent of her chroming, given the contrary evidence that chroming often co-occurs with boredom, I find that endeavours to increase Shyra's sense of purpose in life was an appropriate and necessary component of a multi-faceted approach to her best interests.

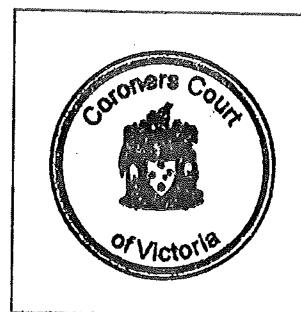
Pursuant to section 73(1) of the **Coroners Act 2008**, I order that finding be published on the internet.

I direct that a copy of this finding be provided to the following:

- Ms Tania McPhelim
- Department of Human Services
- Department of Early Education and Childhood Development
- MacKillop Family Services
- Victorian Aboriginal Child Care Agency Co-operative Limited
- Worowa Aboriginal College

Signature:





CORONER JACQUI HAWKINS
Date: 18 July 2014